LOS ANGELES COUNTY – DEPARTMENT OF HEALTH SERVICES

MY HEALTH LA (MHLA) PROGRAM
MHLA DISENROLLMENT/TRANSFER REQUEST FORM

MHLA Participant Name: _____

MHLA Participant ID: _____

MHLA Clinic Site Name and Address: _____

Date: _____

Incident Description/Reason for Transfer or Disenrollment Request

_____

_____

_____

_____

Do you wish for this patient to be disenrolled or transferred from MHLA?
Disenrolled / Transferred (Circle One)

Clinic Manager or Clinic Provider Printed Name: _____
Clinic Manager or Clinic Provider Signature: _____
Telephone No. and Email: _____

☐ Approved ☐ Denied

Comments: _____

_____

_____

_____ _____
Medical Director, Managed Care Services (or Designee) Date

Please provide all supporting documentation with this form and send via secure email to your program advocate.